

What Is Early Intervention Anyway?

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by

Talbot Black

Good morning. My name is Talbot Black, and for the last twenty-nine years (since 1971) I have worked for a national technical assistance center located at the Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill. The center is called NECTAS (National Early Childhood Technical Assistance System) and is funded by the Office of Special Education Programs (OSEP) of the U.S. Department of Education. NECTAS provides assistance to the state agencies in all states and territorial jurisdictions responsible for implementing the early intervention program called for under Part C and the preschool special education programs called for under Section 619 of Part B of the Individuals with Disabilities Education Act (IDEA). NECTAS also provides assistance to some 100 early childhood demonstration, outreach and other projects funded by OSEP.

I can't help but point out that the beginning of my career coincided with the beginning of the SKI-HI Institute. I met its founder, Tom Clark, in the summer of 1972, just after he had received his first demonstration project grant for a home-based early intervention program for young children with hearing impairment. I have been privileged to consult with SKI-HI off and on over the years, and I have learned a great deal about early intervention from Tom and from the work of the SKI-HI Institute, some of which I intend to share with you today. Indeed, I have been privileged, through my national technical assistance work, to observe three decades worth of evolution and development of early intervention for children with disabilities and their families in our country.

What I will be sharing with you today are my personal observations concerning where early intervention is as a field, and what it is that challenges its future. My remarks do not reflect any position of NECTAS, the Frank Porter Graham Child Development Center, and certainly not the Office of Special Education Programs. They are my observations only!

Peter Senge and the concept of mental models

I wanted to begin my remarks today by recommending to you the work of someone outside of the field of early intervention altogether. It is Peter Senge, the author of *The Fifth Discipline* (1990), and more recently *The Dance of Change* (1999).

Senge's primary concern is how an organization can sustain itself in a complex, ever changing, and competitive world, and, at the same time, nurture its members through a supportive, humane organizational environment. He contends that to do this an organization must understand and follow the "art and practice of a learning organization", and that involves the practice of the five disciplines of a learning organization. Three are individual disciplines, ones that are practiced by individuals, and two are shared disciplines that must be practiced as a group. The individual disciplines are: (1) Personal Mastery, (2) Mental Models, (3) Systems Thinking. The two shared disciplines are: (4) Shared Visioning, and (5) Team Learning.

What has really captured and sustained my interest in Senge's concepts is how broad and inclusive their applications can be. My organization, NECTAS, is a "learning organization" where the practice of these disciplines apply. I suspect yours is too. The Frank Porter Graham Child Development Center is a learning organization; so is the entire University of North Carolina at Chapel Hill; so is its basketball team and its football team (actually, given the season we are having, I'd have to question whether the football is currently a "learning organization").

Even my family is a learning organization where the practice of these disciplines applies. Let me illustrate. Take the discipline of mental models for example. Senge says that mental models are internal conceptual frameworks we each possess that tend to shape our perspectives and influence our actions and decisions. We each have many mental models. We are not always conscience of our mental models. Their influence on our thinking and our decisions can easily go unrecognized. Mental models shape and influence virtually all aspects of our lives. Senge also says mental models can be the source of discord and conflict among individuals when their mental models differ or are incompatible with each other.

Among the mental models I bring to my family is a strong and well-developed mental model of "clean and tidy", and personal responsibility for achieving and maintaining clean and tidy. I can apply this mental model to every room in our home. I have a mental model of clean and tidy for the living room, the kitchen, bedrooms, bathrooms, even the inside of the car. My two teen-aged daughters also have a mental model of clean and tidy, and personal responsibility in achieving and maintaining clean and tidy. As you might suspect, my mental model of clean and tidy and their mental model of clean and tidy is very, very, different, and that difference has created a certain amount of discord and conflict between us.

While my wife basically shares my mental model of clean and tidy, and personal responsibility for achieving and maintaining clean and tidy, she does not share my sense of urgency concerning achieving and maintaining clean and tidy throughout the house. She has told me our daughters' mental model of clean and tidy is typical of teenagers, that arguing and complaining (actually she said ranting and raving) will only create a strain in family relationships and won't change anything. She told me I must learn to have patience.

It turns out that the reason my wife is so capable of understanding our daughters' current mental model of clean and tidy is because, according to her mother, when my wife was a teenager she was guided by the same mental model my daughters now employ. My mother-in-law (who, by the way, shares my mental model of clean and tidy) is amused by this discord in our family, because it signifies to her that the curse she placed on her daughter many years ago has finally come to pass. It is a curse mothers often place on their children. It goes something like this, "I hope when you grow up and have children, that they behave just like you regarding (and here you can fill in the blank with the specifics of the curse)." Apparently, these curses work!

Now, in order to acquire patience, I needed to practice another of Senge's disciplines, personal mastery. I can report that, while I have been a slow learner, I have been somewhat successful in regard to acquiring patience. My wife also said we should sit down and talk about this together with our children, calmly. This involved practicing Senge's discipline of team learning. And, after a couple rounds of family dialogue, I discovered my wife was right. Good family relationships are certainly more important than achieving and maintaining my mental model of clean and tidy.

But something in our family life has changed recently. It has caused my wife to embrace a sense of urgency about clean and tidy that now far exceeds my own. You see, we have decided to sell our house and buy another one. Now there will be strangers coming to our home and looking in every room. Everything must be clean and tidy each and every day, just in case a realtor brings a prospective buyer to tour our home. And I'm pleased to say that we are now achieving my mental model of clean and tidy every day! How can this be? Apart from the fact that now my wife has said it must be achieved, and she wields the real power in the family, it is because we have all adopted what Senge calls a shared vision for our family's future, i.e., moving to a new house. That shared vision has helped us move beyond the conflict and discord of differing mental models and work together to achieve our shared vision.

What is early intervention?

Getting back to what challenges us in the field of early intervention, those of us working in the field of early intervention, like the members of my family, have different mental models of what early intervention is. While these mental models share some common features, they also differ in some important ways that I think tend to create discord and conflict among us. It may even be that some of our different mental models are, in fact, incompatible with each other.

I think our different mental models for early intervention tend to agree on what “early” means. We all understand and appreciate the critical importance of the early years, the importance of what happens during the first years of life in shaping the long-term development of an individual, particularly one with or at risk of a disability. If the early years are a critical period in an individual’s development, then it is also the optimum time to provide help, regardless of whether a disability may already be present or there is a risk that the individual may develop a disability. That is the fundamental rationale for early intervention for children with or at risk of disabilities. I think everybody seems to agree with that much.

It is concerning the “intervention” part of early intervention where our mental models differ. Let me describe two distinct and different mental models for what “intervention” is. The first mental model understands early intervention to be what we do as early interventionists. In other words, the time we as early interventionists spend with the child and the family is the early intervention.

The first mental model of early intervention is supported in the federal IDEA legislation under Part C. Part C defines early intervention as discreet services, and requires that qualified personnel must provide those services. The first mental model is also supported by the way early intervention is financed. For the most part, what is paid for under early intervention is the time and effort of the early intervention professionals. Since what early interventionists do is what gets paid for, that must be what early intervention is.

The second mental model for early intervention understands early intervention to be primarily, what happens with the child and family between the times we, as early interventionists, are with them. In this mental model the most significant early intervention occurs, not when we, as early interventionists, are present, but when we are absent. This mental model recognizes that, during this critical early period in the life of the child and family, virtually everything going on in the family’s life influences the current and future growth and development of a young child with a disability. Early intervention becomes an effort, shared by the family and the early interventionists, to see that all aspects of the child’s life nurtures the child’s development. The role of early interventionists is to help assure that early intervention for the child is introduced and sustained throughout the daily life and routines of the family, not just when the early interventionist is present.

This second mental model is also supported in the IDEA Part C legislation, but in a more indirect way. First, it is supported through the way disability is defined in Part C. Unlike the rest of IDEA where traditional categories of disability are used, a child under Part C is considered to be disabled by either having significant developmental delay or having an established condition that has a high probability of resulting in developmental delay. Not only is developmental delay used to define disability in Part C, it also shapes the purpose of early intervention. The purpose of early intervention is to nurture the development of the child and ameliorate as much as possible delays in the child’s development. Many things in a child’s daily life and routines can influence the development of the child, any child. And we know that a child’s development is nurtured most directly and pervasively by the family and those who care for the child on a daily basis. The second mental model for early intervention recognizes that effective intervention during the child’s critical early period of life must encompass more than the brief amount of time when the child is in the presence of an early interventionist. In fact, when you think about it, doesn’t it seem rather presumptuous, maybe even arrogant, to assume that the relatively brief amount of time an early interventionist spends with a child and family during this critical early period is somehow so powerful that it alone becomes the primary intervening event in the life of a young child with a disability.

Another way in which the second mental model is supported in the Part C legislation is through the law’s provisions concerning natural environments. Part C requires that early intervention must be provided in natural environments “to the maximum extent appropriate.” In fact, a written justification is required whenever

an early intervention service is to be provided in a setting other than a natural environment. Natural environments are defined as, “settings that are natural or normal for the disabled child’s age peers who have no disability and includes the home and community settings in which children without disabilities participate.” For those who see early intervention according to the second mental model, the natural environments provisions seem to strongly encourage incorporating early intervention into the daily routines and lives of children and families, rather than requiring them to be taken out of those routines in order to receive early intervention. However, for those who see early intervention according to the first mental model, providing early intervention in natural environments is often seen as a burdensome and more expensive way to provide their time and effort to the child and family.

Remember what Senge said about mental models, that they shape our thinking and influence our actions and decisions, that they are often unconscious and their influence on us can go unrecognized, that holding different mental models can cause discord and conflict among people. These two mental models for early intervention are (or seem to be) at odds with each other. Are they a source of discord and conflict within the field of early intervention? Which mental model do you think best represents what early intervention is? If neither do, what is your mental model of early intervention?

Other mental models and early intervention

There are other mental models out there in fields related to early intervention that can influence the way we think about early intervention. For example, there is a mental model for healthcare. It is based on the concept of “health” as a desired state of being. If someone departs from the desired state of health, it is the task of healthcare professionals to intervene in ways that will restore the person to health. It can also be the responsibility of healthcare professionals to intervene in ways that maintain an individual’s health so they are less likely to depart from health. Healthcare professionals may even be involved in defining and redefining what “health” is for an individual, including an individual with disabilities.

While I don’t think the mental model for healthcare is at odds with early intervention, I think it is not adequate to fully embrace early intervention because it is not the true linear mental model early intervention requires. By that I mean the healthcare mental model is more cyclical than it is linear. If a person strays from “health”, healthcare intervenes to restore health, and either awaits for the next episode of “illness” and/or strives to maintain the status quo, i.e., health. On the other hand, early intervention, by focusing on child development, seeks to accomplish (or approximate) over time a longitudinal sequence of developmental milestones during the early years, that in turn lead to further developmental milestones on the journey to adulthood. Early intervention is linear, not cyclical.

Another mental model from a related field that influences early intervention is the mental model for special education. A key aspect of the mental model for special education is that public education is something to which a child with a disability has a right, just like any other child who is a citizen of a particular state. IDEA, Part B, promises a free appropriate public education (FAPE) for all children with disabilities. The specific special education and related services that enable the child to benefit from FAPE become something a child with a disability is “entitled” to receive. Consequently, the planning of special education and related services is often shaped by determining what the child is, and is not, entitled to receive from the school in order to achieve FAPE.

I think the mental model of special education, while invaluable in assuring children with disabilities full access to our public education system, becomes problematic when applied to early intervention. Early intervention is not FAPE for babies! There is no right to early intervention for all infants and toddlers in a state in the way there is a right to public education for all children of school age in a state. Early intervention for young children with disabilities is not based on a right of citizenship, but on the recognition that the first years of life for a child with a disability, or at risk for a disability, is a critical time when early intervention will have long term benefits for the child, the family, and society as a whole.

One thing that both the healthcare and special education models share is that trained professionals are the ones most directly responsible for what is to be done with/for the child. While parent involvement is vital to the success of special education, it is the teachers and those who play that role who are on the “frontline”

with the child on a day to day basis seeing that the child receives FAPE. While parents can play a vital role in helping restore and sustain the health of their child, it is the healthcare professionals who are on the front line, determining what is needed and should be done to restore and sustain a child's health.

But who is on the frontline is different when it comes to early intervention, depending upon which mental model for early intervention you follow. If you follow the first mental model then, like health and special education, trained professionals are the ones on the front line. But, if you follow the second model and the overall development of a child is the focus, who are the persons most responsible for nurturing the development of a child on a day to day basis? Are they not the child's parents and those whom the parents have chosen to care for their child? And, if parents are the frontline when it comes to nurturing the child's development, what then is the role of the early intervention professional in supporting the development of the child?

A parent professional partnership

I have come to believe that providing early intervention requires a unique partnership be established between the family of the child and the early intervention professionals. Focusing on a child's development means the early interventionists must attend to how the family can be supported in sustaining their child's development, not just what should be provided to the child by early intervention professionals. The settings in which early intervention professionals attend to the developmental needs of the child and provide enabling support for the family need to be where the family members are living their daily lives: including the home, childcare, and other community based settings. The role of the early intervention professional is often a consultative or advisory role to family members and other care providers, not just "hands on" with the child. The decisions about what will be a part of the plan for the child are shared among the family members and the early intervention professionals. All of these things are features of what I see as a unique partnership between families and early intervention professionals that are necessary because the focus of early intervention is development, not education or healthcare.

But, perhaps the most important feature of the unique partnership between families and early intervention professionals is that for most families, it is the first of many partnerships, and as such it is likely to have a strong shaping influence for the family. It may shape their expectations for future relationships with other professionals throughout their child's formative years. It may shape the understanding of their role in working with others concerning their child. It may shape their attitudes about themselves as decision-makers on behalf of their child. It may even help shape their understanding of who their child is and can become.

I remember a conversation I had with Tom Clark, back in the mid 1970s. SKI-HI had been providing home based early intervention for a few years by that time. Tom said that many aspects of the intervention program were proving to be of value, such as providing hearing aids as early as possible and selecting a communication approach to follow early on (oral or total communication). But, he said, "If I was only able to provide the one thing through early intervention that would be of most benefit to the child, it would be the support and council to the parents that enables them to nurture the growth and development of their hearing impaired child."

In talking with family members over the years, I have been struck by what a powerful influence a competent and caring professional can be for a family during those critical early years. Even after ten, fifteen, twenty years, the memory of a particular person and what that person did for the family during the child's earliest years remains very much alive as a part of their personal history. Families still speak of such a person with fondness and gratitude, even when they have not spoken to the person in many years. Unfortunately, today that first partnership is often extremely short lived before it must be dissolved, and I'll have more to say about that in a minute.

So there are several mental models out there that tend to shape our perspectives and influence our actions and decisions. What is your mental model of early intervention? How does it define your role, your relationship with other professionals and most importantly your relationship with the family and the child?